TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Emergency Rule
LSA Document #12-396(E)

DIGEST

Temporarily amends 405 IAC 1-12-1, 405 IAC 1-12-3, 405 IAC 1-12-11, and 405 IAC 1-12-26 to revise rate-setting criteria for nonstate-owned intermediate care facilities for the mentally retarded and community residential facilities for the developmentally disabled. Adds provisions at 405 IAC 1-12-3 concerning actions to be taken when provider records have inadequate or incomplete documentation. Adds provisions at 405 IAC 1-12-11 concerning the maximum time period for a related party exception. Adds provisions at 405 IAC 1-12-26 concerning requirements for initiating a provider appeal and concerning the office's implementation of Medicaid rates and overpayment recovery prior to the conclusion of the administrative appeal process. Temporarily amends 405 IAC 1-14.6-1 through 405 IAC 1-14.6-4, 405 IAC 1-14.6-7, 405 IAC 1-14.6-9 through 405 IAC 1-14.6-12, 405 IAC 1-14.6-14, 405 IAC 1-14.6-18, and 405 IAC 1-14.6-22 to revise rate-setting criteria for nursing facilities. Adds provisions at 405 IAC 1-14.6-3 concerning additional action that shall be taken if provider documentation submitted is inadequate or incomplete. Adds provisions at 405 IAC 1-14.6-4 concerning requirements for the Employee Turnover Report and the Special Care Unit Report. Adds provisions at 405 IAC 1-14.6-10 concerning costs that are not considered allowable and that shall not be included in the computation of rates. Adds provisions at 405 IAC 1-14.6-11 concerning the allowable costs of nonstate government owned nursing facilities and concerning the maximum time period for a related party exception for nursing facilities. Adds provisions at 405 IAC 1-14.6-22 concerning the office's implementation of Medicaid rates prior to the conclusion of the administrative appeal process. Temporarily amends 405 IAC 1-14.6-24 to revise the nursing facility provider quality assessment fee. Adds provisions at 405 IAC 1-14.6-24 concerning the amount of the provider quality assessment fee, from October 1, 2011, through June 30, 2014, for nursing facilities licensed as a comprehensive care facility. Temporarily repeals 405 IAC 1-14.6-23 and 405 IAC 1-14.6-25. Effective June 28, 2012.

SECTION 1. **(a) This SECTION supersedes 405 IAC 1-12-1(d).**

(b) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process, in accordance with IC 12-15-13-4(e).

SECTION 2. **(a) This SECTION supersedes 405 IAC 1-12-1(e).**

(b) Providers must pay interest on all overpayments, consistent with IC 12-15-13-4. The interest charge shall not exceed the percentage set out in IC 6-8.1-10-1(c). The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists.

SECTION 3. **(a) This SECTION supersedes 405 IAC 1-12-3(a).**

(b) The basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. Costs must be reported in the cost report in accordance with the following authorities, in the hierarchical order listed:

(1) Costs must be reported in accordance with the specific provisions as set forth in this rule, any financial report instructions, provider bulletins, and any other policy communications.

(2) Costs must be reported in conformance with cost finding principles published the Medicare Provider Reimbursement Manual, CMS 15.

(3) Costs must be reported in conformance with generally accepted accounting principles.

SECTION 4. **(a) This SECTION supersedes 405 IAC 1-12-3(c).**

(b) When a field audit indicates that the provider's records are inadequate to support data submitted to the office or the additional requested documentation is not provided pursuant to the auditor's request, and the auditor is unable to complete the audit, the following actions shall be taken:

(1) The auditor shall give a written notice listing all of the deficiencies in documentation.

(2) The provider will be allowed thirty (30) days from the date of the notice to provide the documentation and correct the deficiencies.

(3) Not later than thirty (30) days from the date of the notice described in subdivision (1), the provider

may seek one (1) thirty (30) day extension to respond to the notice and shall describe the reason(s) the extension is necessary.

SECTION 5. **(a) This SECTION supersedes 405 IAC 1-12-3(d).**

(b) In the event the deficiencies in documentation are not corrected within the time limit specified in SECTION 4 of this document, the following actions shall be taken:

(1) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.

(2) The ten percent (10%) reduction shall remain in place until the first day of the month following the receipt of a complete response.

(3) No rate increases will be allowed until the first day of the month following the receipt of the response and requested documentation.

(4) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.

SECTION 6. **(a) This SECTION is supplemental to 405 IAC 1-12-3.**

(b) In the event that the documentation submitted is inadequate or incomplete, the following additional actions shall be taken:

(1) Appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records shall be made.

(2) The audit contractor shall document such adjustments in a finalized exception report.

(3) The rate setting contractor shall incorporate such adjustments in the prospective rate calculations under SECTION 1 of this document.

SECTION 7. **(a) This SECTION supersedes 405 IAC 1-12-11(a).**

(b) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control must be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased as an arm's-length transaction, in an open competitive market.

SECTION 8. **(a) This SECTION supersedes 405 IAC 1-12-11(b).**

(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.

(2) Natural parent, child, and sibling.

(3) Adopted child and adoptive parent.

(4) Stepparent, stepchild, stepsister, and stepbrother.

(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, stepson-in-law, and stepdaughter-in-law.

(6) Grandparent and grandchild.

SECTION 9. **(a) This SECTION supersedes 405 IAC 1-12-11(d).**

(b) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party or the price of comparable services, facilities, or supplies purchased as an arm's-length transaction, in an open competitive market. An exception to this subsection may be granted by the office if requested in writing by the provider before the rate effective date of the review to which the exception is to apply. The provider's request shall include a comprehensive representation that every condition in SECTION 10 of this document has been met. This representation shall include, but not be limited to, the percentage of business the provider transacts with related and nonrelated parties based upon revenue. When requested by the office, the provider shall submit documentation, such as invoices, standard charge master listings, and remittances, to substantiate the provider's charges for services, facilities, or supplies to related and nonrelated

parties.

SECTION 10. **(a) This SECTION supersedes 405 IAC 1-12-11(e).**

(b) The office shall grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization whose services, facilities, and supplies are made available to the public in an open competitive market.

(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization. Transactions with residents of facilities that are owned, operated, or managed by the provider or organizations related to the provider shall not be considered a business activity for purposes of meeting this requirement.

(3) The services, supplies, or facilities are those which commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient or resident care ordinarily furnished directly to patients or residents by such institutions.

(4) The organization actually furnishes such services, facilities, or supplies to other nonrelated party organizations, and the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

SECTION 11. **(a) This SECTION is supplemental to 405 IAC 1-12-11.**

(b) The related-party exception shall be granted for any period of time, up to the maximum period of two (2) years.

SECTION 12. **(a) This SECTION supersedes 405 IAC 1-12-26(a).**

(b) The Medicaid rate-setting contractor shall notify each provider of the provider's rate and allowable cost determinations after they have been computed. If the provider disagrees with the rate or allowable cost determinations, the provider may request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor not later than forty-five (45) days after release of the rate or allowable cost determinations as computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or allowable cost determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, not later than forty-five (45) days from the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in SECTION 14 of this document.

SECTION 13. **(a) This SECTION supersedes 405 IAC 1-12-26(b).**

(b) If the provider disagrees with the preliminary recalculated Medicaid rate or allowable cost redetermination resulting from a financial audit adjustment or reportable condition, the provider may request an administrative reconsideration from the Medicaid audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the Medicaid audit contractor not later than forty-five (45) days after release of the preliminary recalculated Medicaid rate or allowable cost determinations as computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or reportable condition or affirm the original adjustment or reportable condition. The Medicaid audit

contractor shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days from the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under SECTION 14 of this document.

SECTION 14. **(a) This SECTION supersedes 405 IAC 1-12-26(c).**

(b) After completion of the reconsideration procedure under SECTION 12 of this document or under SECTION 13 of this document, the provider may initiate an appeal under IC 4-21.5-3. The request for an appeal must be signed by the provider.

SECTION 15. **(a) This SECTION is supplemental to 405 IAC 1-14.6-1.**

(b) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process, in accordance with IC 12-15-13-4(e).

SECTION 16. **(a) This SECTION is supplemental to 405 IAC 1-14.6-1.**

(b) Providers must pay interest on all overpayments, consistent with IC 12-15-13-4. The interest charge shall not exceed the percentage set out in IC 6-8.1-10-1(c). The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists.

SECTION 17. **(a) This SECTION supersedes 405 IAC 1-14.6-2(b).**

(b) "Administrative component" means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Administrative services and supplies include the following:

(1) Administrator and co-administrators, owners' compensation (including director's fees) for patient-related services.
(2) Services and supplies of a home office that are:
(A) allowable and patient-related; and
(B) appropriately allocated to the nursing facility.
(3) Office and clerical staff.
(4) Legal and accounting fees.
(5) Advertising.
(6) All staff travel and mileage.
(7) Telephone.
(8) License dues and subscriptions.
(9) All office supplies used for any purpose, including repairs and maintenance charges and service agreements for copiers and other office equipment.
(10) Working capital interest.
(11) State gross receipts taxes.
(12) Utilization review costs.
(13) Liability insurance.
(14) Management and other consultant fees.
(15) Qualified mental retardation professional (QMRP).
(16) Educational seminars for administrative staff.
(17) Support and license fees for all general and administrative computer software and hardware such as accounting or other data processing activities.

SECTION 18. **(a) This SECTION supersedes 405 IAC 1-14.6-2(o).**

(b) "Direct care component" means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Direct care services and supplies include all of the following:

(1) Nursing and nursing aide services.
(2) Nurse consulting services.
(3) Pharmacy consultants.

(4) Medical director services.
(5) Nurse aide training.
(6) Medical supplies.
(7) Oxygen.
(8) Medical records costs.
(9) Rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators. Rental cost for these items are limited to $1.50 per resident day.
(10) Support and license fees for software utilized exclusively in hands-on resident care support, such as MDS assessment software and medical records software.
(11) Replacement dentures for Medicaid residents provided by the facility that exceed state Medicaid plan limitations for dentures.
(12) Legend and nonlegend sterile water used for any purpose.
(13) Educational seminars for direct care staff.

SECTION 19. **(a) This SECTION supersedes 405 IAC 1-14.6-2(w).**

(b) "Indirect care component" means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Indirect care services and supplies include the following:
(1) Dietary services and supplies.
(2) Raw food.
(3) Patient laundry services and supplies.
(4) Patient housekeeping services and supplies.
(5) Plant operations services and supplies.
(6) Utilities.
(7) Social services.
(8) Activities supplies and services.
(9) Recreational supplies and services.
(10) Repairs and maintenance.
(11) Cable or satellite television throughout the nursing facility, including residents' rooms.
(12) Pets, pet supplies and maintenance, and veterinary expenses.
(13) Educational seminars for indirect care staff.
(14) All costs related to nonambulance travel and transportation of residents.

SECTION 20. **(a) This SECTION supersedes 405 IAC 1-14.6-2(hh).**

(b) A nursing facility with a "special care unit (SCU) for Alzheimer's disease or dementia" means a nursing facility that meets all of the following:
(1) Has a locked, secure, segregated unit or provides a special program or special unit for residents with Alzheimer's disease, related disorders, or dementia.
(2) The facility advertises, markets, or promotes the health facility as providing Alzheimer's care services or dementia care services, or both.
(3) The nursing facility has a designated director for the Alzheimer's and dementia special care unit, who satisfies all of the following conditions:
(A) Became the director of the SCU prior to August 21, 2004, or has earned a degree from an educational institution in a health care, mental health, or social service profession, or is a licensed health facility administrator.
(B) Has a minimum of one (1) year work experience with dementia or Alzheimer's, or both, residents within the past five (5) years.
(C) Completed a minimum of twelve (12) hours of dementia specific training within three (3) months of initial employment and has continued to obtain six (6) hours annually of dementia-specific training thereafter to:
(i) meet the needs or preferences, or both, of cognitively impaired residents; and
(ii) gain understanding of the current standards of care for residents with dementia.
(D) Performs the following duties:
(i) Oversees the operations of the unit.
(ii) Ensures personnel assigned to the unit receive required in-service training.
(iii) Ensures the care provided to residents of the Alzheimer's and dementia care unit residents is consistent with in-service training, current Alzheimer's and dementia care practices, and regulatory standards.

SECTION 21. **(a) This SECTION supersedes 405 IAC 1-14.6-3(a).**

(b) The basis of accounting under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. Costs must be reported in the cost report in accordance with the following authorities, in the hierarchal order listed:

(1) Costs must be reported in accordance with the specific provisions as set forth in this rule, any financial report instructions, provider bulletins, and any other policy communications.

(2) Costs must be reported in conformance with cost finding principles published in the Medicare Provider Reimbursement Manual, CMS 15.

(3) Costs must be reported in conformance with generally accepted accounting principles.

SECTION 22. **(a) This SECTION supersedes 405 IAC 1-14.6-3(c).**

(b) When a field audit indicates that the provider's records are inadequate to support data submitted to the office, or when the additional requested documentation is not provided pursuant to the auditor's request, and the auditor is unable to complete the audit, the following actions shall be taken:

(1) The auditor shall give a written notice listing all of the deficiencies in documentation.

(2) The provider will be allowed thirty (30) days from the date of the notice to provide the documentation and correct the deficiencies.

(3) Not later than thirty (30) days from the date of the notice described in subdivision (1), the provider may seek one (1) thirty (30) day extension to respond to the notice and shall describe the reason(s) the extension is necessary.

SECTION 23. **(a) This SECTION supersedes 405 IAC 1-14.6-3(d).**

(b) In the event the deficiencies in documentation are not corrected within the time limit specified in SECTION 22 of this document, the following actions shall be taken:

(1) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.

(2) The ten percent (10%) reduction shall remain in place until the first day of the month following the office's receipt of a complete response.

(3) No rate increases will be allowed until the first day of the calendar quarter following the office's receipt of the response and requested documentation.

(4) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.

SECTION 24. **(a) This SECTION is supplemental to 405 IAC 1-14.6-3.**

(b) In the event that the documentation submitted is inadequate or incomplete, the following additional actions shall be taken:

(1) Appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records shall be made.

(2) The audit contractor shall document such adjustments in a finalized exception report.

(3) The rate setting contractor shall incorporate such adjustments in the prospective rate calculations under 405 IAC 1-14.6-1(d).

SECTION 25. **(a) This SECTION supersedes 405 IAC 1-14.6-3(e).**

(b) If a provider has business enterprises or activities other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises or activities shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit or desk review establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs.

SECTION 26. **(a) This SECTION supersedes 405 IAC 1-14.6-4(c).**

(b) The provider's annual financial report shall be completed in accordance with applicable instructions and submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.

(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income, excluding non-Medicaid routine income.
(5) Detail of fixed assets and patient-related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period. Private pay charges shall be the lowest usual and ordinary charge.
(8) Certification by the provider that:
(A) the data are true, accurate, and related to patient care; and
(B) expenses not related to patient care have been clearly identified.
(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.
(10) A copy of the working trial balance that was used in the preparation of the submitted Medicaid cost report.
(11) A copy of the crosswalk document used to prepare the Medicaid cost report that contains an audit trail documenting the cost report schedule, line number, and column where each general ledger account is reported on the cost report.
(12) Any other documents deemed necessary by the office to accomplish full financial disclosure of the provider's operation.

SECTION 27. **(a) This SECTION supersedes 405 IAC 1-14.6-4(k).**

(b) Based on findings from the MDS audit, the office or its contractor shall make adjustments or revisions to all MDS data items that are required to classify a resident pursuant to the RUG-III resident classification system that are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. Such adjustments or revisions to MDS data transmitted by the nursing facility will be made in order to reflect the resident's highest functioning level that is supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. The resident assessment will then be used to reclassify the resident pursuant to the RUG-III resident classification system by incorporating any adjustments or revisions made by the office or its contractor.

SECTION 28. **(a) This SECTION is supplemental to 405 IAC 1-14.6-4.**

(b) The Employee Turnover report (Schedule X) and the Special Care Unit report (Schedule Z) shall be completed by all providers based on the calendar year (January 1 through December 31) reporting period. Schedules X and Z must be submitted to the office not later than March 31 following the end of each calendar year. Reports submitted after March 31 will not be considered in the determination of the subsequent annual rate review.

SECTION 29. **(a) This SECTION supersedes 405 IAC 1-14.6-7(b).**

(b) Notwithstanding 405 IAC 1-14.6-7(a), beginning July 1, 2014, the inflation adjustment determined as prescribed in 405 IAC 1-14.6-7(a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

SECTION 30. **(a) This SECTION supersedes 405 IAC 1-14.6-7(h).**

(b) In place of the CMIs contained in 405 IAC 1-14.6-7(g), the CMIs contained in this SECTION shall be used for purposes of determining the facility-average CMI for Medicaid residents that meet all the following conditions:
(1) The resident classifies into one (1) of the following RUG-III groups:
(A) PB2.
(B) PB1.
(C) PA2.
(D) PA1.
(2) The resident has a cognitive status indicated by a brief interview of mental status score (BIMS) greater than or equal to ten (10) or, if there is not a BIMS score, then a cognitive performance score (CPS) of:

(A) zero (0) – Intact;
(B) one (1) – Borderline Intact; or
(C) two (2) – Mild Impairment.

(3) Based on an assessment of the resident's continence control as reported on the MDS, the resident is not experiencing occasional, frequent, or complete incontinence control.

(4) The resident has not been admitted to any Medicaid-certified nursing facility before January 1, 2010.

(5) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments that are assigned a CMI in accordance with this subsection, then, for purposes of determining the facility's average CMI for Medicaid residents, the assessment or assessments shall be assigned ninety-six percent (96%) of the CMI associated with the RUG-III group determined in this subsection.

RUG-III Group	RUG-III Code	CMI Table	CMI Table
		Effective 10/1/2011, through 12/31/2011	Effective 1/1/2012, and thereafter
Reduced Physical Functions	PB2	0.41	0.30
Reduced Physical Functions	PB1	0.38	0.28
Reduced Physical Functions	PA2	0.32	0.24
Reduced Physical Functions	PA1	0.28	0.21

SECTION 31. **(a) This SECTION supersedes 405 IAC 1-14.6-7(j).**

(b) The office will increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to the facilities at a rate of eleven dollars and fifty cents ($11.50) per Medicaid resident day. The additional reimbursement shall:

(1) be effective on the day the nursing facility provides inpatient services to more than eight (8) ventilator-dependent residents; and

(2) remain in effect until the first day of the calendar quarter following the date the nursing facility provides inpatient services to eight (8) or fewer ventilator-dependent residents.

SECTION 32. **(a) This SECTION supersedes 405 IAC 1-14.6-7(k).**

(b) Beginning July 1, 2003, through June 30, 2014, the office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on the nursing home report card score. For purposes of determining the nursing home report card score rate add-on effective with this rule amendment, the office or its contractor shall determine each nursing facility's report card score based on the latest published data as of the end of the state fiscal year. The nursing home report card score rate add-on shall be computed as described in the following table:

Nursing Home Report Card Score	Nursing Home Report Card Score Rate Add-On
0 – 82	$14.30
83 – 265	$14.30 – ((Nursing Home Report Card Score – 82) × $0.0777)
266 and above	$0

Facilities that did not have a nursing home report card score published as of the most recently completed state fiscal year may receive a per patient day rate add-on equal to two dollars ($2).

SECTION 33. **(a) This SECTION supersedes 405 IAC 1-14.6-7(l).**

(b) Beginning effective July 1, 2003, through June 30, 2014, the office will increase Medicaid reimbursement to nursing facilities that provide specialized care to residents with Alzheimer's disease or dementia, as demonstrated by resident assessment data as of December 31 of each year. The additional Medicaid reimbursement shall equal twelve dollars ($12) per Medicaid resident day in the SCU. Only facilities that meet the definition for a SCU for Alzheimer's disease or dementia shall be eligible to receive the additional reimbursement. The additional Medicaid reimbursement shall be effective July 1 of the next state fiscal year.

SECTION 34. **(a) This SECTION supersedes 405 IAC 1-14.6-7(p).**

(b) For the period from October 1, 2011, through June 30, 2012, the office shall increase Medicaid reimbursement to nursing facilities by seventy-five cents ($0.75) per Medicaid resident day to reimburse costs associated with the following selected facility expenditures:

(1) Rental cost for low air loss mattresses, pressure support surfaces, and oxygen concentrators;

(2) Cable or satellite television provided in resident rooms;

(3) Pets, pet supplies and maintenance, and veterinary expenses;

(4) Direct resident care support and license fees for software to support hands-on resident care;

(5) Replacement dentures for Medicaid residents provided by the facility that exceed state Medicaid plan limitations for dentures; and

(6) Assets identifiable to patient care that conform to the capitalization requirements at SECTION 47 of this document that exceed five hundred dollars ($500), but are less than one thousand dollars ($1,000).

SECTION 35. **(a) This SECTION supersedes 405 IAC 1-14.6-9(a).**

(b) The Medicaid reimbursement system is based on recognition of the provider's allowable costs for the direct care, therapy, indirect care, administrative, and capital components, plus a potential profit add-on payment as defined below. The direct care, therapy, indirect care, administrative, and capital rate components are calculated as follows:

(1) The indirect care and capital components are equal to the provider's allowable per patient day costs for each component, plus the allowed profit add-on payment as determined by the methodology in SECTION 36 of this document.

(2) The therapy component is equal to the provider's allowable Medicaid per patient day direct therapy costs.

(3) The direct care component is equal to the provider's normalized allowable per patient day direct care costs times the facility-average CMI for Medicaid residents, plus the allowed profit add-on payment as determined by the methodology in SECTION 36 of this document.

(4) The administrative component shall be equal to one hundred percent (100%) of the average allowable cost of the median patient day except as follows:

(A) For the period from October 1, 2011, through June 30, 2012, the administrative component shall be equal to one hundred ten percent (110%) of the average allowable cost of the median patient day.

(B) For the period from July 1, 2012, through June 30, 2013, the administrative component shall be equal to one hundred eight percent (108%) of the average allowable cost of the median patient day.

SECTION 36. **(a) This SECTION supersedes 405 IAC 1-14.6-9(b).**

(b) The profit add-on payment will be calculated as follows:

(1) For nursing facilities designated by the office as children's nursing facilities, the allowed direct care component profit add-on is equal to the profit add-on percentage contained in Table 1, times the difference (if greater than zero (0)) between:

(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average CMI for Medicaid residents times the profit ceiling percentage contained in Table 1; minus

(B) the provider's normalized allowable per patient day costs times the facility average CMI for Medicaid residents.

Table 1

Children's Nursing Facilities

	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
Effective Date	**July 1, 2003, through June 30, 2014**	**July 1, 2014, and after**	**July 1, 2003, through June 30, 2014**	**July 1, 2014, and after**
Percentage	**30%**	**52%**	**110%**	**105%**

(2) For nursing facilities that are not designated by the office as children's nursing facilities, the tentative direct care component profit add-on payment is equal to the profit add-on percentage contained in Table 2, times the difference (if greater than zero (0)) between:

(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average CMI for Medicaid residents times the profit ceiling percentage contained in Table 2; minus

(B) the provider's normalized allowable per patient day costs times the facility average CMI for Medicaid residents.

Table 2				
Non-Children's Nursing Facilities				
	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, 2014	July 1, 2014, and after	July 1, 2003, through June 30, 2014	July 1, 2014, and after
Percentage	30%	0%	110%	105%

(C) For nursing facilities not designated by the office as children's nursing facilities, the allowed direct care component profit add-on payment is equal to the facility's tentative direct care component profit add-on payment times the applicable percentage contained in Table 3, based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year.

Table 3 – Allowed Direct Care Profit Add-On Percentage	
Nursing Home Report Card Score	
0 – 82	100%
83 – 279	100% - ((Nursing Home Report Card Score - 82) × 0.50505%)
280 and greater	0%

(D) In no event shall the allowed direct care profit add-on payment exceed ten percent (10%) of the average allowable cost of the median patient day.

(3) The tentative indirect care component profit add-on payment is equal to the profit add-on percentage contained in Table 4, times the difference (if greater than zero (0)) between:

(A) the average allowable cost of the median patient day times the profit ceiling percentage contained in Table 4; minus

(B) a provider's allowable per patient day cost.

Table 4				
	Indirect Care Profit Add-on Percentage		Indirect Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, 2014	July 1, 2014, and after	July 1, 2003, through June 30, 2014	July 1, 2014, and after
Percentage	60%	52%	105%	100%

(C) The allowed indirect care component profit add-on payment is equal to the facility's tentative indirect care component profit add-on payment times the applicable percentage contained in Table 5, based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year.

Table 5 – Allowed Indirect Care Profit Add-On Percentage	
Nursing Home Report Card Score	
0 – 82	100%
83 – 279	100% - ((Nursing Home Report Card Score - 82) × 0.50505%)
280 and greater	0%

(4) The tentative capital component profit add-on payment is equal to sixty percent (60%) times the difference (if greater than zero (0)) between:

(A) the average allowable cost of the median patient day times the profit ceiling percentage contained in Table 6; minus

(B) a provider's allowable per patient day cost.

Table 6		
Capital Component Profit Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, 2014	July 1, 2014, and after
Percentage	100%	80%

(C) The allowed capital component profit add-on payment is equal to the facility's tentative capital component profit add-on payment times the applicable percentage contained in Table 7, based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year.

Table 7 – Allowed Capital Profit Add-On Percentage	
Nursing Home Report Card Score	
0 – 82	100%

83 – 279	**100% - ((Nursing Home Report Card Score - 82) × 0.50505%)**
280 and greater	**0%**

(5) The therapy component profit add-on is equal to zero (0).

SECTION 37. **(a) This SECTION supersedes 405 IAC 1-14.6-9(c).**

(b) Notwithstanding SECTION 35 and SECTION 36 of this document *[SECTIONS 35 and 36 of this document]***, in no instance shall a rate component exceed the overall rate ceiling defined as follows:**

(1) The normalized average allowable cost of the median patient day for direct care costs times the facility-average CMI for Medicaid residents times the overall rate ceiling percentage in Table 8.

Table 8		
Direct Care Component Overall Rate Ceiling Percentage		
Effective Date	**July 1, 2003, through June 30, 2014**	**July 1 2014, and after**
Percentage	**120%**	**110%**

(2) The average allowable cost of the median patient day for indirect care costs times the overall rate ceiling percentage in Table 9.

Table 9		
Indirect Care Component Overall Rate Ceiling Percentage		
Effective Date	**July 1, 2003, through June 30, 2014**	**July 1, 2014, and after**
Percentage	**115%**	**100%**

(3) The average allowable cost of the median patient day for capital-related costs times the overall rate ceiling percentage in Table 10.

Table 10		
Capital Component Overall Rate Ceiling Percentage		
Effective Date	**July 1, 2003, through June 30, 2014**	**July 1, 2014, and after**
Percentage	**100%**	**80%**

(4) For the therapy component, no overall rate component limit shall apply.

SECTION 38. **(a) This SECTION is supplemental to 405 IAC 1-14.6-10.**

(b) The following costs are not considered allowable costs and shall not be included in the established rate:

(1) All over the counter, legend, and nonlegend drugs;
(2) Cost of replacement hearing aids and eyeglasses;
(3) All costs associated with pastoral care;
(4) All costs associated with resident and family gifts, including, but not limited to, flowers, bibles, and memory books;
(5) All costs associated with collection fees;
(6) All costs, fees, and dues associated with lobbying activities;
(7) All costs of acquisitions, such as the purchase of corporate stock as an investment or purchases of new facilities;
(8) All costs associated with barber and beauty shop activities; and
(9) All costs associated with marketing.

SECTION 39. **(a) This SECTION supersedes 405 IAC 1-14.6-11(a).**

(b) For facilities other than nonstate government owned nursing facilities, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control must be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased as an arm's-length transaction, in an open competitive market.

SECTION 40. **(a) This SECTION is supplemental to 405 IAC 1-14.6-11.**

(b) For nonstate government owned (NSGO) nursing facilities, costs applicable to services, facilities,

and supplies furnished to the provider by organizations related by common ownership or control to either the current NSGO provider, or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for the NSGO provider, must be included in the allowable cost of the NSGO provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased as an arm's-length transaction, in an open competitive market.

SECTION 41. **(a) This SECTION supersedes 405 IAC 1-14.6-11(b).**

(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.
(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, stepson-in-law, and stepdaughter-in-law.
(6) Grandparent and grandchild.

SECTION 42. **(a) This SECTION supersedes 405 IAC 1-14.6-11(d).**

(b) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party, or the price of comparable services, facilities, or supplies purchased as an arm's-length transaction in an open competitive market. An exception to this subsection may be granted by the office if requested in writing by the provider before the annual rate review effective date to which the exception is to apply. The provider's request shall include a comprehensive representation that every condition in SECTION 43 of this document has been met. This representation shall include, but not be limited to, the percentage of business the provider transacts with related and nonrelated parties based upon revenue. When requested by the office, the provider shall submit documentation, such as invoices, standard charge master listings, and remittances, to substantiate the provider's charges for services, facilities, or supplies to related and nonrelated parties.

SECTION 43. **(a) This SECTION supersedes 405 IAC 1-14.6-11(e).**

(b) The office shall grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization whose services, facilities, and supplies are made available to the public in an open competitive market.
(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization. Transactions with residents of nursing facilities that are owned, operated, or managed by the provider or organizations related to the provider or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for a nonstate government owned (NSGO) provider shall not be considered an arm's length business activity transacted in an open competitive market.
(3) The services, supplies, or facilities are those that commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.
(4) For facilities other than NSGO nursing facilities, the organization actually furnishes such services, facilities or supplies to other nonrelated party organizations, and the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.
(5) For NSGO nursing facilities, the organization actually furnishes such services, facilities or supplies to organizations that are not related to the NSGO provider or any former provider or related entity that currently serves as the management company or entity in a similar decision making

capacity for the NSGO provider. The charge to the provider shall be:
(A) in line with the charge for such services, facilities, or supplies in the open market; and
(B) no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

SECTION 44. **(a) This SECTION is supplemental to 405 IAC 1-14.6-11.**

(b) The related-party exception shall be granted for any period of time, up to a maximum period of two (2) years.

SECTION 45. **(a) This SECTION supersedes 405 IAC 1-14.6-12(a).**

(b) Providers shall be reimbursed for the use of allowable patient-related facilities and equipment, regardless of whether they are owned or leased, by means of a fair rental value allowance. The fair rental value allowance shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property, except that rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators shall be reimbursed in the direct care component. The fair rental value allowance includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is appropriately allocated to the facility.

SECTION 46. **(a) This SECTION supersedes 405 IAC 1-14.6-12(b).**

(b) The fair rental value allowance is calculated as follows:
(1) Determine, on a per bed basis, the historical cost of allowable patient-related property for facilities that are not acquired through an operating lease arrangement, including:
(A) land, building, improvements, vehicles, and equipment; and
(B) costs;
required to be capitalized in accordance with generally accepted accounting principles. Land, buildings, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the date of facility acquisition to the present based on the change in the R.S. Means Construction Index.
(2) The inflation-adjusted historical cost of property per bed as determined in subdivision (1) is arrayed to arrive at the average historical cost of property of the median bed.
(3) The average historical cost of property of the median bed as determined in subdivision (2) is extended times the number of beds for each facility that are used to provide nursing facility services to arrive at the fair rental value amount.
(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the rate effective date as determined in 405 IAC 1-14.6-6(a). The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.

SECTION 47. **(a) This SECTION supersedes 405 IAC 1-14.6-14(e).**

(b) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least one thousand dollars ($1,000), the cost shall be capitalized and included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

SECTION 48. **(a) This SECTION supersedes 405 IAC 1-14.6-18(a).**

(b) Compensation for:
(1) an owner, a related party, management, general line personnel, and consultants who perform management functions; or
(2) any individual or entity rendering services above the department head level;
shall be subject to the annual limitations described in this SECTION and SECTIONS 49 and 50 of this document. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policymaking, decision making, and

other management functions above the department head level. Beginning effective July 1, 2003, through June 30, 2014, compensation subject to this limitation includes wages, salaries, and fees for an owner, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks. Beginning effective July 1, 2014, and thereafter, wages, salaries, and fees paid for an owner, administrator, assistant administrator, management, contractors, and consultants who actually perform management functions, as well as any other individual or entity performing such tasks, are subject to this limitation.

SECTION 49. **(a) This SECTION supersedes 405 IAC 1-14.6-18(b).**

(b) Beginning effective July 1, 2003, through June 30, 2014, the maximum allowable amount for owner, related party, and management compensation shall be the average allowable cost of the median patient day for owner, related party, and management compensation subject to this limitation as defined in SECTION 48 of this document. The average allowable cost of the median patient day shall be updated four (4) times per year effective January 1, April 1, July 1, and October 1.

SECTION 50. **(a) This SECTION supersedes 405 IAC 1-14.6-18(c).**

(b) Beginning effective July 1, 2014, the maximum amount of owner, related party, and management compensation for the parties identified in SECTION 48 of this document shall be the lesser of the amount:

(1) under 405 IAC 1-14.6-18(d), as updated by the office on July 1 of each year based on the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator; or

(2) of patient-related wages, salaries, or fees actually paid or withdrawn that were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, or fees.

If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or the costs shall be disallowed.

SECTION 51. **(a) This SECTION supersedes 405 IAC 1-14.6-22(a).**

(b) The Medicaid rate-setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate, the provider may request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor not later than forty-five (45) days after release of the rate as computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, not later than forty-five (45) days from the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in SECTION 54 of this document.

SECTION 52. **(a) This SECTION supersedes 405 IAC 1-14.6-22(b).**

(b) If the provider disagrees with the preliminary recalculated Medicaid rate resulting from a financial audit adjustment or reportable condition, the provider may request an administrative reconsideration from the Medicaid audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or authorized representative of the provider and must be received by the Medicaid audit contractor not later than forty-five (45) days after release of the preliminary recalculated Medicaid rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or reportable condition or affirm the original adjustment or reportable condition. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing not later than

forty-five (45) days from the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under SECTION 54 of this document.

SECTION 53. **(a) This SECTION supersedes 405 IAC 1-14.6-22(c).**

(b) If the provider disagrees with a rate redetermination resulting from a recalculation of its CMI due to an MDS audit affecting the established Medicaid rate, the provider may request an administrative reconsideration from the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or authorized representative of the provider and must be received by the Medicaid rate-setting contractor not later than forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall forward the administrative reconsideration to the MDS audit contractor who shall evaluate the data. After review, the MDS audit contractor may amend the audit adjustment or affirm the original adjustment. The MDS audit contractor shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days from the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the Medicaid rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under SECTION 54 of this document.

SECTION 54. **(a) This SECTION supersedes 405 IAC 1-14.6-22(d).**

(b) After completion of the reconsideration procedure under SECTION 51, SECTION 52, or SECTION 53 of this document *[SECTION 51, 52, or 53 of this document]***, the provider may initiate an appeal under IC 4-21.5-3. The request for an appeal must be signed by the nursing facility provider.**

SECTION 55. **(a) This SECTION is supplemental to 405 IAC 1-14.6-22.**

(b) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with 405 IAC 1-14.6-1(d).

SECTION 56. **(a) This SECTION supersedes 405 IAC 1-14.6-24(a).**

(b) Effective July 1, 2011, through September 30, 2011, the office shall collect a quality assessment from each nursing facility licensed under IC 16-28 as a comprehensive care facility based on the most recently completed annual financial report or quality assessment data collection form, as follows:

(1) Privately owned or operated nursing facilities with total annual nursing facility census days fewer than seventy thousand (70,000), fourteen dollars and seventy cents ($14.70) per non-Medicare day.

(2) Privately owned or operated nursing facilities with total annual nursing facility census days equal to or greater than seventy thousand (70,000), three dollars and sixty-eight cents ($3.68) per non-Medicare day.

(3) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated before July 1, 2003, three dollars and sixty-eight cents ($3.68) per non-Medicare day.

(4) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated on or after July 1, 2003, fourteen dollars and seventy cents ($14.70) per non-Medicare day.

SECTION 57. **(a) This SECTION is supplemental to 405 IAC 1-14.6-24.**

(b) Effective from October 1, 2011, through June 30, 2014, the office shall collect a quality assessment from each nursing facility licensed under IC 16-28 as a comprehensive care facility based on the most recently completed annual financial report or quality assessment data collection form, as follows:

(1) Privately owned or operated nursing facilities with total annual nursing facility census days fewer than seventy thousand (70,000), sixteen dollars ($16) per non-Medicare day.

(2) Privately owned or operated nursing facilities with total annual nursing facility census days equal

to or greater than seventy thousand (70,000), four dollars ($4) per non-Medicare day.
(3) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated before July 1, 2003, four dollars ($4) per non-Medicare day.
(4) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated on or after July 1, 2003, sixteen dollars ($16) per non-Medicare day.

SECTION 58. **(a) This SECTION supersedes 405 IAC 1-14.6-24(b).**

(b) Pursuant to IC 16-28-15-7(2), the following nursing facilities shall be exempt from the quality assessment described in SECTION 56 of this document:
(1) A continuing care retirement community that meets one of the following criteria:
(A) A continuing care retirement community that was registered with the securities commissioner as a continuing care retirement community on January 1, 2007;
(B) A continuing care retirement community that for the entire period of January 1, 2007, through June 30, 2009, operated independent living units, at least twenty-five percent (25%) of which are provided under contracts that require the payment of a minimum entrance fee of at least twenty-five thousand dollars ($25,000);
(C) An organization registered under IC 23-2-4 before July 1, 2009, that provides housing in an independent living unit for a religious order; or
(D) A continuing care retirement community that meets the definition set forth in IC 16-28-15-2.
(2) A hospital-based nursing facility licensed under IC 16-21.
(3) The Indiana Veterans' Home.

SECTION 59. **(a) This SECTION supersedes 405 IAC 1-14.6-24(e).**

(b) The office or its contractor shall notify each nursing facility of the amount of the facility's assessment after the amount of the assessment has been computed. If the facility disagrees with the computation of the assessment, the facility shall request an administrative reconsideration by the Medicaid rate-setting contractor. The reconsideration request shall:
(1) Be in writing.
(2) Contain the following:
(A) Specific issues to be reconsidered.
(B) The rationale for the facility's position.
(3) Be signed by the authorized representative of the facility.
(4) Be received by the contractor not later than forty-five (45) days after the notice of the assessment is mailed.
Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the assessment or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the facility of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the facility's reconsideration request, the request shall be deemed denied and the provider may initiate an appeal under IC 4-21.5-3.

SECTION 60. **(a) This SECTION supersedes 405 IAC 1-14.6-24(i).**

(b) The office shall offset the collection of the assessment fee for a facility as follows:
(1) Against a Medicaid payment to the facility.
(2) Against a Medicaid payment to another health facility that is related to the facility through common ownership or control.
(3) In another manner determined by the office.

SECTION 61. **(a) This SECTION supersedes 405 IAC 1-14.6-24(j).**

(b) If a facility:
(1) fails to submit patient day information requested by the office to calculate the quality assessment fee; or
(2) fails to pay the quality assessment fee;
not later than one hundred twenty (120) days after the patient day information is requested, or payment of the quality assessment is due, the office shall report each facility to the state department of health to initiate license revocation proceedings in accordance with IC 16-28-15-12.

SECTION 62. THE FOLLOWING ARE TEMPORARILY REPEALED: 405 IAC 1-14.6-23; 405 IAC 1-14.6-25.

SECTION 63. SECTIONS 1 through 62 *[of this document]* expire on June 30, 2013.

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